City of Long Beach Department of Health and Human Services
Epidemiology/Communicable Disease Control Program
2525 Grand Avenue, Suite 201
Long Beach, California 90815
Phone: (562) 570-4302 | Fax: (562) 570-4374

ZIKA VIRUS (ZIKV) TEST SCREENING QUESTIONNAIRE FOR PROVIDERS

Instructions & Criteria for Zika Virus Testing

Please complete this questionnaire and include relevant supporting documentation, such as a history and physical and lab results. All requests for Zika virus testing must be submitted with this questionnaire and the Long Beach Public Health Laboratory Test Request Form. Testing will only be approved if question #1 is checked 'Yes' and the patient meets at least one of the five criteria listed in question #4. This questionnaire is for health care provider use only and not for general circulation or public release.

Patient Information

Name (Last, First, Middle Initial) | Date of Birth | Age

Sex: ☐ Male ☐ Female Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ Asian/Pacific Islander ☐ Other

Address (Number, Street, Apt. Number) | City | State | Zip Code

Medical Record Number | Home Phone Number | Cell Phone Number

Previous Testing?

Chikungunya: ☐ Positive ☐ Negative ☐ Equivocal ☐ Pending ☐ Not Done
Dengue: ☐ Positive ☐ Negative ☐ Equivocal ☐ Pending ☐ Not Done

Vaccination History?

☐ Yellow Fever
☐ Japanese Equine Encephalitis

Relevant Infectious Disease History?

☐ Dengue ☐ Chikungunya ☐ West Nile virus ☐ TORCHS (toxoplasmosis, rubella, CMV, herpes, HIV, syphilis)

Pregnant?

☐ Yes ☐ No ☐ Unknown

If 'Yes,' then Age of Gestation | Estimated Date of Delivery

Infant Name (Last, First, Middle Initial), If Applicable | Date of Birth | Sex ☐ Male ☐ Female | Age

Provider Information

Physician/Provider Name | Facility Name

Email Address | Pager/Phone Number | Fax Number

Point of Contact for Lab Specimen | Contact Phone Number | Contact Email Address

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Yes	No	Criteria
☐	☐	**1.** Has the patient or their sexual partner travelled to or resided in a region with ongoing ZIKV transmission in the past 2-12 weeks? Please visit http://www.cdc.gov/zika/geo/index.html for an up-to-date list of areas with ongoing Zika virus transmission prior to completing this question. If 'Yes,' then who travelled? ☐ Patient ☐ Patient's Sexual Partner Country of travel/residence (list all applicable countries)? _____ _____ Dates of patient's travel/residence? From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____ Reason for travel? ☐ Business ☐ Vacation/Visiting Family ☐ Permanent Residence ☐ Other: _____
☐	☐	**2.** Is the patient pregnant?
☐	☐	**3.** Does the patient have at least 2 of the following symptoms? ☐ Fever (≥ 38° C) ☐ Maculopapular rash ☐ Arthralgia ☐ Nonpurulent conjunctivitis ☐ Other: _____ Onset date: _____

Yes	No	Criteria
☐	☐	**4.** Does the patient fit into at least one of the five categories below:
☐	☐	**a. Symptomatic Pregnant Traveler** ☐ Symptom onset within 14 days of return **or** ☐ Symptom onset during travel
☐	☐	**b. Asymptomatic Pregnant Traveler** ☐ Within 12 weeks after return from travel
☐	☐	**c. Pregnant Traveler or Infant of a Recently Pregnant Traveler** ☐ Evidence of microcephaly or intracranial calcifications detected on fetal ultrasound ☐ Evidence of microcephaly in an infant
☐	☐	**d. Symptomatic Non-Pregnant Traveler (Male or Female)** ☐ Symptom onset within 14 days of return from travel
☐	☐	**e. Guillain-Barré Syndrome Diagnosis**

For LBDHHS Staff Use Only

Reviewed by: _____ Date: _____ ☐ Approve Testing ☐ Deny Testing